Report on RCS Clinical Capacity
For Counselors and Team Leaders

February 16, 2015

TEAM: Fourteen members, one Team Leader and Counselor from each of the 7 regions.

TASK: Define the working clinical capacity for Counselors and Team Leaders

POLICY REV: The current RCS Policy manual was reviewed to find any existing references to "Capacity" and the only reference found is stated here: "(1) **Veteran Centric Care** - Extend Vet Center capacity to provide quality readjustment counseling services to eligible Veterans and their families in or near their respective communities."

DRIVING PRINCIPLES: **VA CORE VALUES:**

Integrity: "Act with high moral principle. Adhere to the highest professional standards. Maintain the trust and confidence of all with whom I engage". We have strived to provide accurate data and to identify areas where the program can enhance data integrity as well as other areas of improvement.

Commitment: "Work diligently to serve Veterans and other beneficiaries. Be driven by an earnest belief in VA's mission. Fulfill my individual responsibilities and organizational responsibilities." As a team, we have done everything possible to promote VA's mission in this endeavor. We agreed to identify issues that may be considered "unpopular, tacit and perhaps un-solicited" but as a team, we believe they are paramount to success of this task.

Advocacy: "Be truly Veteran-centric by identifying, fully considering, and appropriately advancing the interests of Veterans and other beneficiaries." Many of the team's discoveries reveal unintended consequences that burden our veterans and employees, and are directly tied to the capacity issue at hand. Most significant, is the compensation time for counselors. Across industry and government, compensation time was created to reduce and or share the burden of overtime expense. The use of comp-time with FLSA exempt employees creates a burden on the clinicians and ultimately our veterans. The team consensus, recommends this shift be reversed, to avoid future burnout of clinicians and reduced services (capacity) to veterans, thereby appropriately returning this burden back to the Agency.

Respect: "Treat all those I serve and with whom I work with dignity and respect. Show respect to earn it". This team consisted of a cohesive group that stayed on task and dedicated their time to this objective. We faced our differences and put aside our fears to present a cohesive presentation of facts in a respectful professional manor.
Excellence: "Strive for the highest quality and continuous improvement. Be thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes, and rigorous in correcting them." The team would like to humbly admit that our short time together, we have assuredly made some mistakes in this endeavor and therefore, recommend hiring a professional consulting team consisting of methods specialists, statisticians and engineers to perform time studies to eliminate any appearance of bias found within this report.

Plain Writing Act: Public Law 111–274 111th Congress

METHODS: Policy Review, data collection, research and consultation across team members covering all Regions within RCS. The data, when viewed across different Vet Centers clearly revealed an unacceptable or inconsistent range of data to incorporate into a quantifiable and defensible data set, if we included data from multiple Vet Centers.

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FOCUS: Our focus was narrowed to one Vet Center in Midland, Texas RCS-3B #0716.
The decision was arrived at for purposes of accuracy and validation of data collection. Counselor capacity is assumed to be static across RCS however; Vet Center over-all capacity and to an equal degree, Team Leader capacity varies to such a high degree that it prohibited a cross section presentation of clinical data.

DISCOVERY:

RCS currently has a serious data integrity issue across the program. The following illustrate these anomalies:

- A systemic lack of data verification protocol and monthly reconciliation at the Vet Center level.
- A systemic failure to capture real or accurate data Nation Wide.

RCS-NET data is not precise and does not provide decision makers with consistently valid information. These identified inconsistencies result in a distorted perception of clinical capacity. This is likely a result of depending on an outdated but accurate standard, combined with efforts to meet or exceed 50% total activity time or twenty hours of forty. We discovered that work hours have been manipulated or under reported in Vet Centers across most Regions. Many counselors log 8 hours worked even when actual hours worked exceed 8 hours in one day. Furthermore, in some

Regions, the Team Leader has been coerced to under report clinical visits on a given day in order to avoid showing that output exceeds 100%. It is understood that output cannot exceed capacity or 100% however; data manipulation has become the norm in most locations. When employees work 10 hours in a day and actually produced 10 hours service time; those 10 hours would be logged as 8 hours worked and reducing the true output (omitting 2 hours) to reflect a distorted 125% activity time… to correlate with the 8 hours logged as worked. The importance of lost activity time and hours worked cannot be over-emphasized in this endeavor. Additional discoveries include:

- Inconsistency across VISN's related to VA training requirements in (TMS). Mandatory training fluctuates across Regions. Additionally, a minority of Team Leaders has obtained TMS administrative rights to remove trainings that are not required by RCS; like "hand hygiene and infection control" just two of many examples. This inconsistency will result in a small variance across Regions but presents a negative impact on clinical capacity.
- Interpretation of RCS Policy has resulted in a large variance across RCS. Multiple policies have clearly been lost-in-translation; across all Regions and this has a very significant influence on clinical capacity. For example, some Team Leaders provide (1 hour) supervision to counselors on a weekly basis while other Team Leaders provide the required supervision on a monthly basis. The policy could for purposes of argument, result in a Team Leader providing supervision every six months. The policy is written as follows: "…Team Leader is responsible for providing individual counseling supervision to Vet Center counselors on an ongoing and regularly recurring basis." While the intent is to provide flexibility for newer employees, this has produced drastic differences across RCS. This issue is further exacerbated by the size of the Vet Center clinical staff, when a Team Leader spends six or seven hours per week providing supervision to all clinical staff.

ANALYSIS:

We began from the historic standard of 50% activity time which basically consisted of capturing all productive hours worked both clinical and non-clinical to include Counseling, Education, Consultation, Supervision, Travel, Outreach and COTR duties. The 50% standard originally encompassed both Clinical (Direct) and Non-Clinical (Indirect) service time. This standard was the established norm until around 2012 when the norm of 50% Total Activity Time was verbally modified to be 50% Direct (Clinical) Service Time. This was not updated in the policy manual 1500.02. In 2014 some performance plans required 60% Direct Service time. It is unknown by this team what effect that may have had on the over-all output, if any. It appears, to have been motivated solely by a desire to increase output. It is doubtful this informal modification to the Standard had any real measurable effect on output.

The task of this team was to identify the real clinical capacity of a licensed counselor working for RCS. The objective was to identify all non-clinical, internal and external demands, from OPM, VISN's, Regional Managers and Central Office, that take priority over clinical work. In addition to identifying these internal draws from capacity, it was agreed that we must then identify all other non-clinical demands such as (1) Professional demands and licensure requirements, literature review demands etc. (2) Internal and External Customer Service Demands such as other stake-holders, co-workers and other internal departments like fiscal, contracting, mental health, logistics, IT etc. and ultimately, we had to identify all other demands that would be categorized as (3) Universal demands such as reading/writing emails, phone calls etc. All of these resources in one way or another influence or reduce our real capacity, which is limited by time constraints of 2080 hours per year.
We defined our time constraints on the following: 365.25 days per fiscal/calendar year or 12 months or 52 weeks and reduced that to our available working capacity which is 52 weeks or 260 work days or 2080 available work hours across one year.

We began by deducting all internal capacity draws or employee benefits such as:

Federal Holidays (OPM Fixed)	80 hours per year
Annual Leave (OPM Variable)	156 hours per year
Sick Leave (OPM Variable)	104 hours per year
Required Work Breaks (OPM Fixed)	130 hours per year
Office of Personnel Management (OPM) demands total	**470** hours per year

These fixed and variable OPM demands totaling 470 hours per year is deducted from the fixed available work hours of 2080 per year and reduces our clinical capacity by **22.6%** of total work hours. Note: the Annual leave ranges from 104 to 208 hours per year depending on clinician's length of service with VA and we used the mid-point. The sick leave ranges from 104 to 408 hours per year and the number we used; 104 hours does not include bereavement, FLMA or disabled veteran's allotment of 104 hours of up-front sick leave provided on day one of employment. OPM draws alone, leave us with 77.4% available capacity across any time period from one day, week, month, pay-period or year. While use of various types of leave occur sporadically across the year, the total must be leveled across all available work days.

Next we identified all VISN demands that vary across different VISN's (See Spreadsheet Tab labeled "Variances Across Regions." VISN 18 is used in the Tab 1 for Midland, Texas only. VISN demands are as follows:

TMS online trainings (VISN 18)		19.25 hours per year
Annual Flu Shot (Travel Time Included)		1.75 hours per year
Annual TB Test (Travel Time Included)		1.75 hours per year
PIV Badge Renewal every two years (2 Trips)		1.75 hours per year
Vista Data Entry for annual or sick leave		1.10 hours per year
VISN Demands	**Total**	**25.6 hours per year**

This VISN demand of 25.6 hours per year takes another 1.2% away from the maximum available 2080 hours per year so now we have arrived at a total deduction for both OPM and VISN demands of 23.82% of the 2080 and now we are left with 76.18% of available capacity or 1,584.4 hours for potential clinical output.

Next, we identified all Central Office and Regional Demands that also vary across Regions due to policy interpretation, communication breakdown and variable demands, Regional preferences etc. We identified the following as C.O. and R.O. demands:

Int/Ext Case Staffing Demand (Non-Clinical Producing)	48 hours per year
Staff Meeting Attendance (Varies Across Program)	12 hours per year
Monthly Supervision with Team Leader (Variable)	12 hours per year
Administrative Site Visit (Meet with RO Staff)	1.1 hours per year
Clinical Site Visit (Meet with RO Staff)	1.1 hours per year
STEPs Updated for annual site visits	1.2 hours per year
RCS-Net Data Entry (Non-Clinic) Hrs., Edu, Conslt Time	19.5 hours per year
RCS-Net Downtime - Updates during work hours.	1.5 hours per year

Central Office and Regional Office demands Total 96.4 hrs per year

This Central Office or Regional Office demand total of 96.4 hours per year represents another 4.63% of reduced clinical capacity. When included with other non-clinical demands; OPM 480 hours, VISN 25.6 hours and Central Office/Regional demand of 96.4 hours per year for a total of 602 hours reduction from max available working hours of 2080; leaves only 1,488 hours per year or 71.54% remaining clinical capacity.

Finally, we identified professional or State demands for licensure requirements. This will vary across States, license held and when multiple licenses are held, this will variable will increase somewhat. Referring to Tab 1 on the spreadsheet or the actual capacity calculations in Midland, all counselors are LCSW's and require 30 CEU hours every two years or 15 per year. Most conferences that offer CEU's offer a maximum of 7 hours in a full-day presentation. As a result, we calculated a counselor would take 2.5 days off each year to satisfy this State Requirement for licensure:

State or Licensure Demands Total 20 hours per year

Subtracting these 20 hours from the above remaining hours of 1488, we get 1468 available hours or 70.57% remaining clinical capacity.

We then combined all other demands for counselors ranging from Team Leader Demand to Universal Demands such as email reading/writing/response/saving/

and included duplicating daily output onto (an electronic SARS spreadsheet for comparison with RCS-Net data to assure data integrity). We identified the following:

National PTSD Conference Calls (TL Demand)	12 hours per year
Email writing/response/saving (Universal Demand)	42 hours per year
Scheduling Appointments (outlook or other)	19 hours per year
Not included are MST, LMFT Conf Calls	0 hours per year
Literature Review (Professional Demand)	3.5 hours per year
Time duplicating electronic SARS (TL Data Integrity)	10.5 hours per year
NOT INCLUDED: *Annual Counselor Training*	***(40) hrs per year***

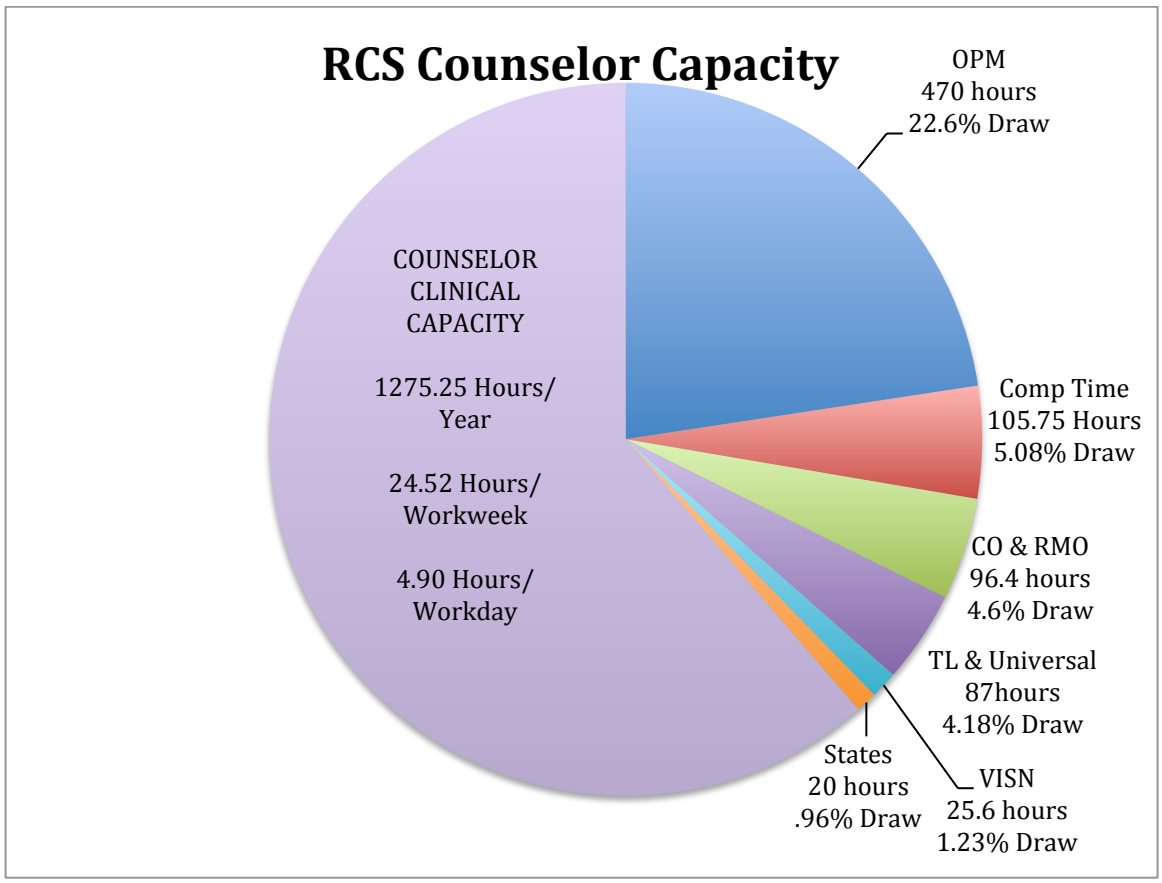
Team Leader & Universal Demands Total **87 hours per year**

The total Team Leader and Universal Demands represent 87 hours per year. This sub-set represents another 4.18% draw from maximum working capacity of 2080. We subtract these 87 hours from the above total of 1468 and we arrive at 1381 available hours in the year to provide clinical services. This represents our best estimate for a Counselor's Clinical Capacity. 1381 hours remain from a total of 2080 max capacity hours in a given work year or across 260 workdays. This leaves us at 66.3% clinical capacity from 2080 per year. This leaves only one remaining variable to calculate.

Compensation Time and Over Time:
Hours authorized when demand exceeds capacity in an 8-hour day or over 40 hours in a week.

Using real data from approved compensation request records, we see that another 105.75 hours were allotted to a Midland clinician for hours worked in excess of 8 per day. This counselor worked approximately 120 miles away from the Vet Center in San Angelo Texas. He stayed over-night two nights each week and worked three full days on Tuesday, Wednesday and Thursday and returning to Midland late Thursday evening. The clinician without requesting comp time or overtime donated these 8.5 hours. In February 2014, a new mandate from RCS-3B RMO; he was then required to request and take all comp time earned within the next three pay periods. This policy resulted in his working only 4 days each week and lowered his (un-captured) individual clinical capacity from 260 max days in a work year to 208 thereby reducing his capacity by 20%. These additional hours must be acknowledged for capacity calculation as it represents both reality and the historic inappropriate distribution of the burden onto RCS clinical staff. In this example, the capacity burden, carried by the staff member, was then shifted onto the veteran or customer. The employee is compensated (time for time) and all is equal between the Agency and the clinician. The burden shifts to the veterans because the counselor was not available on day five of the workweek. This intangible loss is frequently over-looked because the veteran or customer does not complain. Therefore, the end result for determining clinical capacity is as follows:
Total remaining time from above deductions is 1381 remaining hours to provide clinical services, minus the 105.75 Comp time hours (that were productive) leaving

a grand total of 1,275.25 hours across a year to allocate for clinical capacity. We have now calculated and lost 38.69% of our maximum 2080 available work hours to internal/ external and customer demands. This leaves only 61.31% clinical capacity from the maximum 2080 hours in a year. In hours per year we are left with 1,275.25 and in a month we are left with only 106.27, while weekly we have 24.52 hours for Counselors to provide clinical services. (See spreadsheet Cell I36). When viewed across a workday, the counselor is left with only 4.90 hours (Clinical Capacity) per workday to provide clinical services. (See Cell K36) Note: to meet the historic 50% Standard, the clinician must capture 4.0 hours of the remaining 4.9 hours available in a work day.



The second task is to identify Team Leader Capacity (internal and external demands) in addition to, the clinical demands measured above. Since the Team Leader is or perhaps should be a clinician, the starting place for Team Leaders is the same capacity of 24.52 hours per week for counselor clinical capacity. In 2014, the standard or expectation for Team Leaders was reduced from 50% to 25% Direct Service Time or 10 hours per workweek. So a Team Leader is starting with 24.52 hours per week and additional demands cannot fall below 10 hours or capacity will be exceeded. This leaves 14.52 hours per week for Team Leader to navigate all other internal and external customer demands. In the interest of brevity, this report will summarize the identified Team Leader draws from identified capacity of 24.52

hours per week. We will identify both the range of draws and discuss the largest impact draws. Our presentation will not be as detailed as above but all data collected can be quickly referenced in the spreadsheet (and verified upon request) for a more detailed critique. Verification would involve printing or providing copies of thousands of emails processed in 2014 among other things.

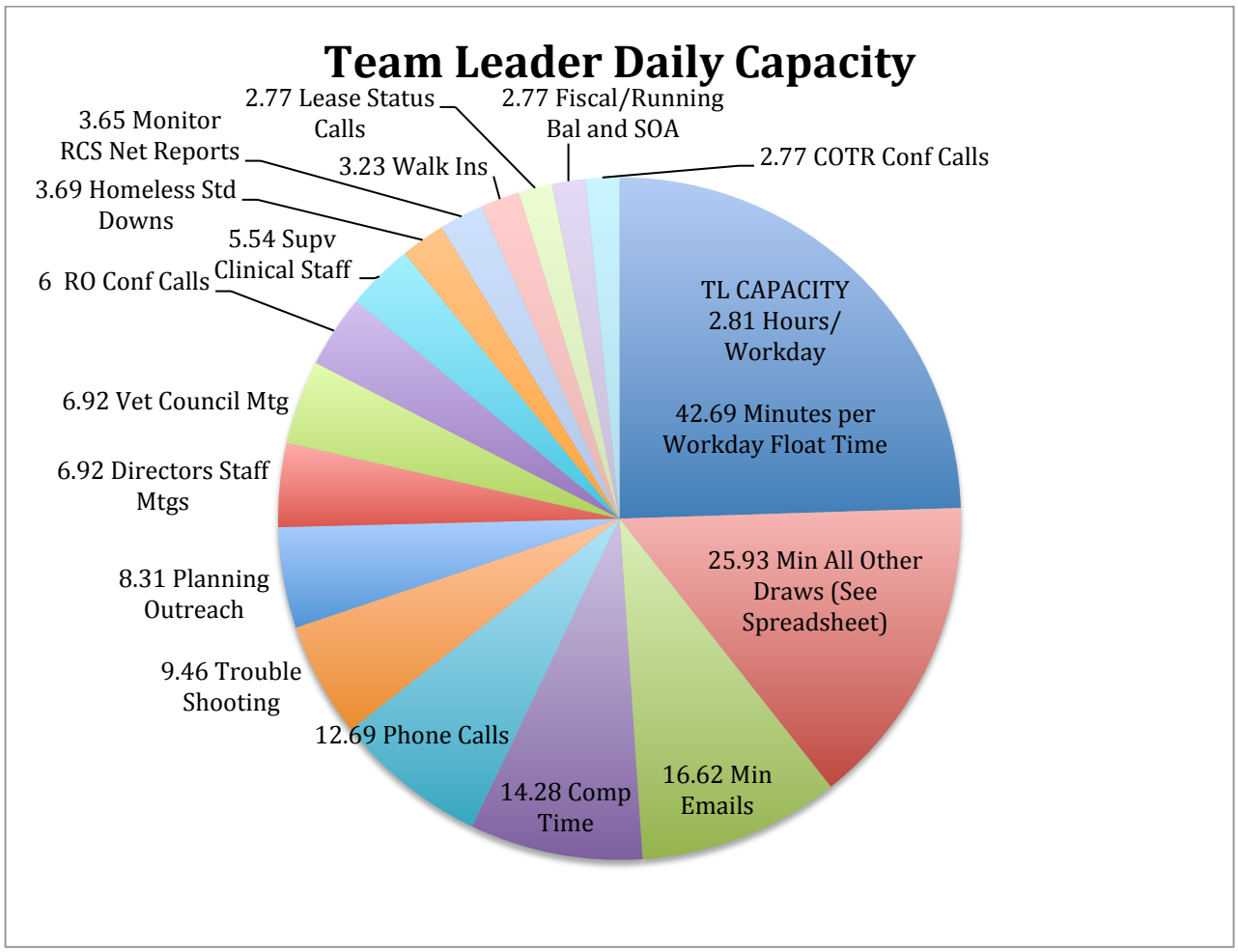
To begin, the range from low to high percentage draws is from 0.0096% to "Monitor Staff Licensure for Timely Renewal" (TL Demand) to a high of 3.8798% to account for "Email Writing and Response/Staff/RO/CO and Support Facility" (Universal Demand). The data to support this significant draw was captured from FY 2014 email traffic. With such a large range of draws, we have chosen to display in this report, **only those draws in excess of 0.5%**. In an effort to fine-tune the draws, we look at daily draws, not weekly.

For a quick review of the chosen range to include in descending order, we found the following for Midland 0716:

• All Other Draws	5.4014%	**25.93** minutes "(Cell L60)
• Emails	3.8798%	16.62 minutes per day
• Comp Time	2.9760%	14.28 minutes "
• Phone Calls/Response	2.6442%	12.69 minutes "
• Trouble Shooting	1.9712%	9.46 minutes "
• Planning Outreach	1.7312%	8.31 minutes"
• Directors/Staff Meetings	1.4423%	6.92 minutes "
• Veterans Council Meetings	1.4423%	6.92 minutes "
• RO Conference Calls	1.2500%	6.00 minutes "
• Supervise Clinical Staff	1.1541%	5.54 minutes "
• Homeless Stand Downs	0.7692%	3.69 minutes "
• Monitor RCS-Net Reports	0.7596%	3.65 minutes "
• Walk-Ins to Center	0.6731%	3.23 minutes "
• Lease Status Calls	0.5769%	2.77 minutes "
• Running Balance/SOA	0.5769%	2.77 minutes "
• COTR Conf Calls	0.5769%	2.77 minutes "

Total TL Draws from available Capacity in a Work Day is 131.55 minutes per workday

Conclusions from the above calculations illustrate the Team Leaders clinical capacity across one workday. Evenly spread across the 260 workdays per year and 40 hours per week with 8 hours per day, our research reveals the following: Remember, the smaller draws are not included in the chart below; therefore, the numbers will not match exactly with the calculations on the spreadsheet.



Referring back to spreadsheet, Hours available per **workweek** for Team Leaders to provide Clinical Services is **14.07 hours** See Cell (I-116)

Hours available per **workday** for Team Leaders to provide Clinical Services is **2.81 hours see** Cell (K-116)

Almost complete, but one critical element must be addressed. The fact of Clinical Staff and Team Leaders donating their undocumented and untraceable personal time to the program and veterans that creates a ***"False Capacity."*** In other words, the Capacity Constraints are clearly defined by time and are indeed FIXED. (365.25 days, 12 Months, 52 Weeks, 260 Work Days and 2080 Work Hours) We have previously discussed the lack of data integrity and the negative impact of authorizing "Compensation Time." A quick review reminds us that compensation time ultimately places the burden onto the veteran or customer. Now, we must look at the effects of this "False Capacity" (resulting from donated time) as it can and does have a vast impact upon Capacity. This issue of donated time cannot easily be tracked across our existing RCS-NET database. It has been either inaccurately

reported or completely unreported by both Counselors and Team Leaders and on occasion, guided by the Regional Management.

To illustrate the effects of this phenomenon, the Midland Vet Center tracked these hours and our spreadsheet allows for this on TAB 1 "Capacity Breakdown" Line 107. An explanation can be found in Cell D107. When we include these seemingly insignificant 35 hours of donated time over a brief 4-month period, the effects are surprising. This donation over 4 months would equal 105 hours over one year. The instructions provided on the spreadsheet, requests that we enter these as a NEGATIVE number because the formulae are designed to subtract. Simply entering as a negative 35 hours will illustrate the cause and effect of ADDING FALSE CAPACITY. This field can be loaded with projected data (negative) to illustrate the significance of DONATED TIME. We urge the reader to fill this cell with 105 to illustrate the effects spread over one year. In our analysis we used "Real Data" and therefore included the negative 35 hours to measure the affect on "real" capacity for Team Leaders, which was identified earlier as being:

14.07 Hours Per Work Week Capacity (Cell I 116)
2.81 Hours Per Work Day Capacity (Cell K 116)

Now if we remove those -35 hours in Cell D-107 our available capacity is reduced to:

13.39 Hours Per Work Week Capacity
2.68 Hours Per Work Day Capacity

Removal of this negative 35 hours results in a capacity decrease, because it was added value (capacity) that frequently never gets captured or measured. At first glance, these numbers may seem insignificant but with further scrutiny reveals this **.68** (From above 2.68 and using only the difference from 2.82 and 2.68) hours or 40.8 minutes per workweek becomes significant. When viewed across a workday we see the decrease went from 2.81 hours down to 2.68 hours for a difference of .13 hours or **7.8 minutes across every single workday in the year**. Recall if you will; these 35 documented hours were donated by one staff member from Oct 13 thru Jan 14… only four months, and yet it clearly demonstrates a significant impact on Actual Capacity. The impact of this is certainly positive for the Agency but eventually has catastrophic effects on the staff member. It creates the illusion of capacity that never existed, but surfaced from employee donations. When or if, you multiple this 35 donated hours over 4 months by 3 to get an annual view, you would end up with 105 hours of false capacity and hours worked but not logged or counted, and thereby distorting our real capacity. Calculated out this represents **23.4** minutes per day across an entire year…given to the program. This value exceeds all other significant draws in this report with the single exception of the sum of "All Other Draws" of **25.93** minutes (See Chart Above).

This data and charts will hopefully demonstrate that many of our Vet Centers have exceeded their real capacity and have survived only due to the significant

contributions of the Clinical Staff. We pray, this is presented without bias and can be further challenged by professional capacity planners/consultants. We recommend this practice of allowing employees to donate personal time to create unavailable capacity for the Agency, be stopped. This most assuredly leads to burnout and turnover rates, which is very costly to the Agency.

CONSIDERATIONS AND RECCOMENDATIONS OF THIS WORKING GROUP

The working group would like to acknowledge many years of success with the "Top-Down" approach that resulted in the long standing 50% activity time standard. Our research confirms both the efficacy and accuracy of that standard. It worked when the program was young and has continued to work as we have grown. We are now at a turning point due to growth and demands for both clinical and non-clinical time. We are grateful for the growth in the program as well as the opportunity to present our working group findings to Central Office.

Moving forward, we recommend a "Bottom-Up" approach for identifying actual or real capacity in order to meet current and future demands. The historical Top-Down (Central Office to RO to Vet Center) will no longer provide adequate outcomes due to the many variances and programmatic problems discovered by this group. We consider any attempt to accurately identify capacity from the top would be futile and ultimately destructive to the program. Furthermore, the lack of existing valid data can be better managed at the Central Office level, yet the capacity planning can be better managed with a "Bottom-Up" approach based on our findings. A Vet Center Team Leader can use the "rough" methods contained in our spreadsheet however; we believe a professional tool would be most helpful as some Team Leaders are not spreadsheet friendly. With our current National budget, we would request hiring a consulting firm to verify, formalize and enhance our findings. Team Leaders can use their own data to identify their Vet Center Capacity and seek approval and over-site from the Regional Office. Once approved at the Regional level, a tertiary review can be done in Washington. It is abundantly clear and supported by the team conclusions, that a "Bottom-Up" approach is needed to move RCS forward now and in the 21st Century.

CLINICAL STAFF SUPERVISION: We recommend a clarification to the existing RCS Policy Manual 1500.02 to quantify and clarify expectations for supervision. The ambiguity must be eliminated to resolve this significant capacity draw. Improved communications alone, could resolve this issue without the need to modify existing policy.

DATA INTEGRITY: We propose or recommend Central Office standardize across all regions, a data integrity policy. Consider creating a full time position, to improve communication and ensure, consistent data entry and data integrity. This data must be accurate for harvest at the local, regional and national levels. The importance of this single issue is further illustrated below.

COMPENSATION TIME, DONATED TIME AND OVERTIME: For Readjustment Counseling Service, we recommend the burden resulting from these variable costs be appropriately returned to the agency. The future use of overtime is both authorized and necessary, while eliminating the negative impact of compensation time on both, our clinical capacity and ultimately, our combat veterans. Once any requested and pre-approved overtime is captured and analyzed, it can be used for critical management decisions such as spotting increased demands, indicating a need for more FTE's at specific locations. Any signs of developing overtime patterns could be addressed quickly by Central or Regional Offices to determine if alternative methods exist, for meeting local client demand. Ultimately, the Team Leader will know of any patterns as they develop. It is fundamentally clear that such a recommendation might create fear of abuse, as is often the case with overtime. In defense of that unrealistic fear, is the demonstrated commitment by longer-term RCS counselors and Team Leaders. Their proven commitment alone should serve to soften those fears for overtime abuse. We remain committed to our mission but can no-longer shoulder these burdens alone. We suggest a review of the employee satisfaction survey to see if RCS employees are satisfied with their pay. We believe such a review would reveal the fact that employee income; is not the real issue, but is growing in strength. We hope the reader will recognize that clinicians stay with RCS because they believe in the mission. A few clinicians leave RCS for the larger VA, and are immediately promoted to the GS-12 level without being a supervisor. Comparatively, RCS pay is capped at the GS-11 grade for equally credentialed counselors. Those clinicians who leave are less committed to the mission and more focused on personal income growth. The professional staff across RCS has proven their dedication to serving our combat veterans and has borne the burden for many years. We believe, we have reached a critical-mass, whereby counselors and Team Leaders are being stretched too far. Once this tipping point is reached, it will have catastrophic effects on RCS as a whole and most importantly on our combat veterans. No one wants this to come to fruition and thus far, the professional employees of RCS have single handedly avoided this outcome for the veteran, on behalf of the Agency. We pray the reader recognize these facts and implement a solution, before we reach the cliff.

POLICY EFFECTS ON CAPACITY: We recommend that RCS continue as it has historically and until recently, to adhere to the RCS Policy Manual 1500.2. We have recognized a pattern that has a direct or indirect impact on Capacity. Non-adherence to existing RCS Policy on the part of leadership creates fear and uncertainty among the frontline staff. We submit two policy examples that affect capacity in support of this recommendation:

1. Annual Training for Staff: Policy indicates that RCS "must" provide staff with annual training… This affects capacity planning and has been omitted in our conclusions and calculations herein. Much like OPM policies must be included, we believe RCS policy should also be included. Since the team has no knowledge and little hope that annual training will be returned; we chose

to omit it in our analysis. We have included 2.5 days per year for clinicians to take off, to obtain required CEU's. These 2.5 days is 50% of the five-day annual training draw that is NOT included in this report but clearly would provide great benefit to staff and ultimately our combat veterans.

2. Vet Center HOURS of Operation: Current policy indicates (7) "Upon request from Veterans, Vet Centers will maintain non-traditional appointment schedules, after normal business hours during the week and on weekends, to accommodate working Veterans and family members." We ask as a group; "When did this change"? Vet Centers are in process of being expected to work specific hours after the normal TOD and on Saturdays. This "Top-Down" approach creates further fear and confusion as it not only contradicts existing policy, but also serves to tacitly refer to the presumed incompetence of Team Leaders. We have always accommodated client demands for both, after hours and weekends. If a few Team Leaders have failed in this objective, please consider removing them from their position. This decision appears on the surface to be based on a need to have "talking points" rather than on actual veteran needs. Furthermore, we believe our recommendation to shift to a "Bottom-Up" Capacity planning approach would also result in better staff utilization across the program. We as a working group have no idea where or who has determined that our capacity can be so easily stretched with no concerns for the affects on RCS staff. We want to emphasize that our objective is not one of complaint or resistance but one of rational acknowledgment of a fluctuating demand that can best be identified at ground zero. There was great debate whether this should be included herein and it was decided we should include it simply, because it impacts capacity and therefore falls within our assigned purview.

SUMMARY: *A NEW SET OF LENSES*

We believe the efforts of this working group can be considered a success IF, the reader is able to walk away with a "New Set of Lenses" from which to view the output of our Vet Center teams. If no single recommendation we have proposed is accepted and absolutely nothing changes moving forward; the front line workers will collectively know, that we gave our best. Our present staff and those who served before us have sacrificed for the survival and success of RCS. To illustrate this new insight or perspective let us look at the output measurements anew and as follows:

COUNSELORS: (Current Standard) 50% Direct Service Time
50% Direct Service Time requires 20 clinical hours to include travel, individual and groups per week. 20 hours of clinical output across 40 available hours per week. Now we know from the results of this working group that one counselor has only 24.52 hours of real capacity across the week. Therefore, if the counselor's clinical output is equal to 20 hours per week, this would meet the historic expectation of 50% Direct Service Time.

This translates to a **production output efficiency rating of 81.56%** (20 of 24.52). This has always been the minimum acceptable output rate when compared to the historic 50% standard of measurement. Now let us look with renewed clarity, at the recent expectation to obtain a 60% direct service time.

60% Direct Service Time requires 24 clinical hours to include travel, individual and groups per week. 24 hours of clinical output across 40 available hours per week. Now we know from the results of this working group that one counselor has only 24.52 hours of real capacity across the week. Therefore, if the counselor's clinical output equals 24 hours per week, this would meet the 2012 adjusted expectation of 60% Direct Service Time however; this translates to a **production output efficiency rating of 97.87%** (24 of 24.52). This is unsustainable over time and will lead to burnout.

TEAM LEADERS: (Current Standard) 25% Direct Service Time
50% Direct Service Time (Historically) required 20 clinical hours/travel, individual or groups per week in addition to meeting other Team Leader duties. 20 hours of clinical output across 40 available hours per week. Now we know from the results of this working group that one Team Leader has only 14.7 hours of real capacity across the week. This clearly shows the Team Leader capacity was exceeded when 50% was the norm. This now translates to a **production output efficiency rating of 136.05%** because the maximum capacity is only 14.7 hours. Fortunately, this was recognized in or around 2012 and the expectation for Team Leaders was informally reduced to 25% Direct Service time. Using this 2012 expectation we can draw the following conclusion. When the Team Leader produces 10 hours of clinical output (10 of 40 = 25%) across a workweek the minimum goal has been met. This results in an efficiency rating of **68.02%** or (10 of 14.7) Caution is called for here, as the reader's first impression when reading **68.02%** efficiency could easily lead to a first impression; this is under-performance. To clarify the small range involved in this Team Leader capacity (10 of 14.7) let us note that only 4.7 hours per week or 56 minutes per day, remains available to the Team Leader. To illustrate:

1 more hour of clinical work in a workweek = 74.82% Efficiency
2 more hours of clinical work in a workweek = 81.63% Efficiency
3 more hours of clinical work in a workweek = 88.43% Efficiency
4 more hours of clinical work in a workweek = 95.24% Efficiency
5 more hours exceeds capacity in a workweek=102% Efficiency

NEW PERSPECTIVE: New Standard Recommendations from this working group

Team Leader weekly capacity is 14.7 hours or rounded up to 15 hours

Counselor weekly capacity is 24.52 hours or rounded up to 25 hours

Lowest Common Denominator is **75**

Team Leader equals 10/15 or 50/75 for an efficiency rating of **66.66%** that aligns with existing expectation of **25% of 40** hour workweek. (Existing Standard) **66.66% Efficient**

Counselor equals 20/25 or 60/75 for an efficiency rating of **80%** that aligns with existing expectation of **50% of 40-hour** workweek. (Existing Current Standard) **80% Efficient**

To balance the demand for Counselors and Team Leaders, we recommend reducing Counselor current expectations by two visits from 20 to 18 clinical hours per workweek. This would result in 18/25 or 54/75 for a balanced efficiency rating of **72%** minimum efficiency. (More realistic than current 80% expectation) Additionally adding one visit hour to Team Leader output from 10 to 11 would result in 11/15 or 55/75 for a balanced efficiency rating of **73.33%. (Balanced across positions)** This difference between the two can be accounted for by the rounding up from 14.7 to 15 for Team Leader Capacity as well as the rounding up from 24.52 to 25 for Counselors.

Outcome:

Team Leader Standards should change to an expected clinical output of **11 visits (clinical hours) per workweek** and Counselors Standards should be decreased to **18 visits (clinical hours) per workweek** based on current data and capacity calculations.

Note: When looking at maximum capacity for both positions, ONLY 3.7 hours (float) (14.7 minus 11) of remaining capacity exists for a TL across any workweek and ONLY 6.62 hours (float) (24.52 minus 18) of remaining capacity exists for Counselors across any given workweek. Additional output from these capacities would look like this:

Team Leaders:	**(FLOAT)**
12/15 or 60/75 would result in an efficiency rating of **80.0%**	**3 Hours**
13/15 or 65/75 would result in an efficiency rating of **86.7%**	**2 Hours**
14/15 or 70/75 would result in an efficiency rating of **93.3%**	**1 Hours**
15/15 or 75/75 would result in an efficiency rating of **100%**	**Max Cap**

Counselors:	
19/25 or 57/75 would result in an efficiency rating of **79.2%**	**6 Hours**
20/25 or 60/75 would result in an efficiency rating of **83.3%**	**5 Hours**
21/25 or 63/75 would result in an efficiency rating of **87.5%**	**4 Hours**
22/25 or 66/75 would result in an efficiency rating of **91.6%**	**3 Hours**
23/25 or 69/75 would result in an efficiency rating of **95.8%**	**2 Hours**

24/25 or 72/75 would result in an efficiency rating of **96.0%** **1 Hour**
25/25 or 75/75 would result in an efficiency rating of **100%** **Max Cap**

The above referenced "Float" in hours per week is the bucket we must pull from to accommodate all other non-clinical demands not accounted for in this report such as Outreach Events (not planning them), PDHRA events, Yellow Ribbon Events, National VA2VETS events, disaster response etc. Across any given **work week** these additional demands **must** come from the 6.62 hour/week bucket for Counselors and 3.7 hour/week bucket Team Leaders. As evidenced by our findings, our remaining (float) capacity for all of these demands remain extremely limited. When viewed by workday, counselors have 79.4 minutes daily float and Team Leaders have 44.4 minutes float time per workday.

KNOWN PROBLEMS AND AREAS FOR IMPROVEMENT:

This data represents a single Vet Center due to the drastic range of variables across RCS Vet Centers and time constraints of this working group. This does not represent a sufficient sample size; therefore, it is suggested that a larger sample of Vet Centers be encouraged to submit their own unique data to Central Office for a better reflection of the uniqueness of each and every Vet Center. The spreadsheet used in this report is readily available for such purpose.

All variables are not captured in this report, such as time spent dealing with staff problems and HR, MST counselors and LMFT counselors who must attend weekly or monthly conference calls. Several such omitted draws can be identified by a larger cross-section of Vet Centers.

EXECUTIVE SUMMARY:

This working group held the first conference call on January 6, 2015 to define the objectives and tasks for the group. We held five weekly conference calls lasting one hour each thereafter, beginning January 16th and ending February 13, 2015. Additional information exchange via phone, email and fax were frequently shared. In hindsight, we should have utilized our Tandberg system for those five conferences, as most members have never met in person. We want to emphasis, the majority of work was completed after work hours and primarily on weekends. We volunteered to participate and therefore eagerly donated our personal time to this endeavor.

We began with a policy review of RCS 1500.02, which revealed only one reference to Capacity and that reference emphasized our historical adherence to "Veteran Centric Care." We then agreed to be guided in our

efforts by the VA-RCS Core Values and Principles of Integrity, Commitment, Advocacy, Respect and Excellence! We further agreed to submit a report designed to communicate rather than impress; so we adopted the "Plain Writing Act: Public Law 111-274 from the 111th Congress.

Our findings revealed many systemic failures across the program and at all levels from Central Office, Regional Offices and Vet Centers. Each of these misfortunes has tremendous impact on clinical capacity. Of these, we identified the key problems: (1) Policy and it's wide-ranging Interpretation; (2) Ineffective and conflicting Communication across Regions; and a most significant failure was found across our (3) data entry, collection and validation process or lack thereof. A systemic failure to monitor data entry, data verification and data analysis was discovered to be paramount. This is a systemic failure and not isolated to RCS-Net design, but shared more by Central Office, Regional Offices and Vet Centers specifically.

Our analysis of all components that influence capacity within RCS began with our long-standing goal for clinicians and Team Leaders to maintain 50% total activity time. Our detailed analysis validated the efficacy and accuracy of this standard. We were able to fine-tune the existing standard to a more precise level. As our program has grown over the years, so too have our shortcomings. These historic and new influences are now having significant negative impacts across the program.

The group identified both internal and external sources that pull from our maximum clinical capacity and we refer to that as "draw." We agreed to first focus on one clinician or licensed counselor. We then agreed that the identified counselor capacity would be the "starting" place for calculating team leader capacity. The rationale is that most if not all, team leaders are also licensed counselors and therefore are subject to the same internal and external draws as all counselors.

Throughout this report, we frequently reference the long-standing 50% total activity time that included outreach, education, consultation, and COTR. (Managing clinical contractors) We also occasionally reference how that standard has evolved over the past few years. First, it was modified from 50% TOTAL to 50% DIRECT meaning time spent in outreach, education and consultation were removed. It is assumed, the standard evolved from "total to direct" because of a misconception on some level, that the remaining 50% or twenty hours per week, was untapped. This report demonstrates this was never the case.

A major discovery is the significant impact on capacity that "Compensation Time" has had. While it appears to be a flexible means of addressing demand, the use of such, reduces real capacity over time. An equally important issue is the apparent desire of RCS management to avoid the use of overtime to

meet temporary excess demands. Our research reveals that overtime would not only improve data integrity, but also our ability to capture real program costs for budget planning. The use of overtime would also prevent employee burnout.

Our review at the ground level of RCS (Vet Centers) exposed a major unintended consequence of the long-standing measurement of 50% activity time. This unintended consequence has resulted in devoted clinical staff donating their personal time toward our Veteran Centric Mission. Some forms of these donated hours have been captured by RCS-Net however; most have not. The reasons for not capturing these hours are many; such as (1) hours never reported by staff, (2) efforts to manipulate activity time by staff, (3) motives to distort and improve reported activity time by Regional Offices, (4) the systemic failure to measure the use and impact of compensation time, and finally; what the working group identified as **the single most important and <u>intended consequence</u> demonstrated daily by RCS staff as follows:** (5) **Integrity "…**highest professional standards…" of RCS staff; **Commitment** "…diligently serving veterans…an earnest belief in VA's mission and fulfillment of my individual responsibilities and organizational responsibilities" by RCS staff; **Advocacy** "…being truly Veteran Centric and advancing the interest of Veterans…" by RCS staff; **Respect** "What other explanation exists for RCS client satisfaction" than Vet Center staff; and finally, **Excellence** "striving for the highest quality and continuous improvement…being thoughtful and decisive in leadership, accountable for my actions, willing to admit mistakes and rigorous in correcting them."

ADDENDUM:

We requested by did not receive, data on the number of requested and or approved hours for compensation time Nationwide. We did however; receive last minute delivery of data requested from RCS-Net; we add the following brief analysis of Region 3B data in support of our summary. The data received, was precisely as requested. Several hours of data correction and analysis was needed to eliminate incongruities. The data set covered Region 3B for FY 2014. Hours captured for Outreach, Outreach Workers, MVC drivers, temporary staff, office managers etc. were removed. The focus of the data was limited to (1) Readjustment Counselors (2) Team Leaders (3) MST Counselors and (4) LMFT Counselors…all clinical staff ONLY. The data included all working activity performed daily and entered into RCS Net for every day in FY 2014. It consisted of over 34,000 rows of data. It was broken down by Vet Center, Position, Staff Name, Hours Logged as Worked, Hours for Individual sessions, Hours for Group sessions, Hours for family sessions and the sum of those last three for a field called Total Hours worked.

In support of the group's conclusions that we have a systemic data integrity problem, the following was revealed in the eleventh hour data set.

- From 34,000 plus daily entries of Hours worked, over 1700 were blank even though work time had been allocated for those days.
- Outreach was originally included and only distorted the real focus.
- Specific Vet Centers are donating more hours and some Vet Centers donate zero hours. Donated hours are revealed when the sum of total output across a day is greater than the hours entered as worked.
- Specific staff members are clearly giving of themselves to the point they will burnout.
- Vet Centers that were added to RCS from a previous realignment never donated time in FY 14. The unique number of Vet Centers in 3B that are outside of the normal 0700 series identified this.
- 55 Clinical staff donated one hour or less over FY 14
- 24 Clinical staff donated over one week in FY 14
- 7 Clinical staff donated over two weeks or 80 hours in FY 14
- 2 Clinical staff donated over three weeks or 120 hours in FY 14
- 10 Vet Centers donated over 100 hours in FY 14
- 3 Vet Centers donated over 200 hours with the highest being 290.8 hours
- 9 Vet Centers in Region 3B made zero donations in FY 14

The quick review of the corrected RCS Region 3B data for FY 14 revealed the following facts:

3052 Extra work hours were donated
381.5 Extra workdays
76.3 Extra workweeks
6.36 Extra months
1.47 Extra work years for one person

It would require 1.47 Full Time employees working 2080 hours at 100% Efficiency without missing days to replace donated time.

$117,318.88 is the added value of these donations to Region 3B. If paid at the minimum overtime rate of GS-10 Step 1 at 1.5 or $25.62 times 1.5 would equal an overtime rate of $38.44 per hour which is usually less than the regular hourly rate of clinicians in RCS. Clinicians get the higher of the two rates.

Now, let's look on the National level by simply multiplying the numbers above by 7.

21,364 Extra work hours are projected to have been donated
2,670 Extra workdays

534 Extra workweeks
44.5 Extra months
10.27 Extra Work Years for one person

It would require 10.27 Full Time employees working 2080 hours at 100% Efficiency without missing days to replace donated time.

$821,232.16 is the added value of these donations on a National level and if paid at the minimum overtime rate of GS-10 Step 1 multiplied by 1.5 or $25.62 times 1.5 or $38.44 per hour which is usually less than the regular hourly rate of clinicians in RCS. Clinicians get the higher of the two rates.

We would like to thank Michael Fisher from Central Office, Don Smith, Acting Chief RCS and each and every Regional Manager for allowing us the opportunity to participate on this working group. In addition, special thanks to the RCS-NET team who provided us with much needed data.

Respectfully Submitted,

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